

Oakland County Health Plan Enrollment Form

For Employees Hired On or After 05/31/2003.
Waiting Periods apply to those hired Part-time eligible.

DPDT _____
DE _____

Employee ID #:

Please print your name below:

Your name as it is displayed on your Social Security Card	Last	First	Middle	M <input type="checkbox"/>	Married <input type="checkbox"/>	Date of Birth	/	/
				F <input type="checkbox"/>	Single <input type="checkbox"/>			

Home Address	City	State	Zip
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Home Telephone	Work Telephone	Social Security No.	Full-time <input type="checkbox"/>	New Hire <input type="checkbox"/>	Date of Hire	/	/
			Part-time <input type="checkbox"/>	Re-hire <input type="checkbox"/>			

(Mark the Plan of Your Choice for Medical & Dental)	Select One Medical Coverage	Select One Dental Coverage
	<input type="checkbox"/> Comprehensive Major Medical (CMM) (M1, M2, M3) <input type="checkbox"/> BC/BS Blue Preferred Plan (PPO) (P1, P2, P3) <input type="checkbox"/> No Medical Coverage (N1, N2, N3) (Please complete "Medical Other Coverage" below) <input type="checkbox"/> Is Your Spouse A County Employee? (NS1, NS2, NS3) (Please complete "Medical Other Coverage" below)	<input type="checkbox"/> Dental Coverage (789) <input type="checkbox"/> No Dental Coverage (16,17,18) (Please complete "Dental Other Coverage" below) <input type="checkbox"/> Is Your Spouse A County Employee? (19,20,21) (Please complete "Dental Other Coverage" below) <input checked="" type="checkbox"/> Vision Coverage (required) - List Dependents below. (10,11,12)

IMPORTANT - List Family Members you are covering. Please include last name if different from yours. Social Security Numbers are required.

- A Photocopy of the Birth Certificate or Marriage License is required for each member listed.
- Legal Documentation is required for any adoption or legal guardianship.

NAME	SS# required	BIRTH DATE	Sex	Relationship
Spouse				

Medical Other Coverage Verification:

I am currently enrolled in _____ through _____ Health Policy
 my _____'s coverage with _____
Relationship Name of Company or Organization

Dental Other Coverage Verification:

I am currently enrolled in _____ through _____ Health Policy
 my _____'s coverage with _____
Relationship Name of Company or Organization

I apply on behalf of myself and eligible family members, as listed, for enrollment in the health plan selected above as currently offered through Oakland County. I hereby revoke all previous enrollment applications executed by me for hospital and medical coverage as made available by Oakland County. Remember, no matter which health plan you choose, you elect a plan not a specific provider. If I selected the NO COVERAGE option, I realize my next opportunity to enroll may be as long as 1 year from this date.

I certify the above information is true and correct to my knowledge and belief. I have provided the required legal documents to add dependents to my coverage and certify that they do not have other coverage available through their own or their spouse's employer. Improperly enrolling or continuing coverage for an ineligible spouse or child may result in both recovery of improperly paid claims and potential disciplinary action, up to and including termination, if determined to be inaccurate.

Subscriber's Signature: _____ Date: _____

Effective Date	Group/Suffix	Service Code	_____
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ENROLLMENT FORM TERMS AND CONDITIONS

Your signature on the front side of this form indicates your understanding that Oakland County will enroll you and your eligible dependents for medical, dental, vision and prescription drug coverage made available by Oakland County for which you are eligible and which you have not waived or canceled, with the health carrier you have elected and constitutes your authorization to Oakland County or any of its agents to release to all carriers or organizations, as applicable, the information contained on this form.

Your signature on the front side of this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare approved organization or provider of service to release any information requested with respect to a claim to the health carrier in which you are enrolled, or to the state or federal government, in situations involving processing or auditing of claims or investigation of fraud; in conformance with HIPAA.

Your signature on the front side of this form constitutes your authorization to Oakland County, until this authorization is revoked as allowed under Flexible Benefit Plan rules, by you in writing, to deduct in advance each month from any earned or accrued wages due, such amount as may be necessary to make any contributions required of you. These include, by way of example, but not limited to, County bi-weekly health care contribution amounts.

If in any month you are not eligible to receive any earned or accrued wages, your signature on the front side of this form constitutes your agreement to pay in cash to Oakland County the full monthly subscription charges on or before the first of the month for which coverage is to be provided.

Dependent Children Eligibility Requirements:

You may enroll your children who meet all of the following eligibility requirements: 1. Your child by birth, legal adoption or stepchild; 2. The child has not reached his or her 26th birthday; 3. The child does not have other health coverage available (whether or not they are actually enrolled) through their own employer or if married, through their spouse's employer. Your children through legal guardianship may be covered if they are: 1. Unmarried; 2. Their legal residence is with you; 3. You provide over half of their support.

In all cases, photocopies of birth certificates, marriage license and adoption/legal guardianship documents **must be** attached to this form for family members to be enrolled.

Other terms and conditions apply according to the specific plan in which you are enrolled.

This form should only be used for those employees hired on/after 05/31/2003 and does not apply to those in Bargaining Unit 10.

Revised: 09/2010